IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
KARL B. KURTZ – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 8804

June 12, 2006

Joseph Rudd, Administrator
Life Care Center of Treasure Valley
502 North Kimball Place
Boise, ID 83704

Provider #: 135123

Dear Mr. Rudd:

On **June 2, 2006**, a Recertification survey was conducted at Life Care Center of Treasure Valley by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiencies to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached CMS-2567 whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 26, 2006**. Failure to submit an acceptable PoC by **June 26, 2006**, may result in the imposition of civil monetary penalties by **July 17, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **July 7, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **July 7, 2006**. A change in the seriousness of the deficiencies on **July 7, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 7, 2006** includes the following:

Denial of payment for new admissions effective **September 2, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 2, 2006**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene

Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 2, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

This request must be received by **June 26, 2006**. If your request for informal dispute resolution is received after **June 26, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey at the facility. The surveyors conducting the investigation survey were: Lorna Bouse, BSW, Team Coordinator Nicole Martin, RN Barbara Franek, RN Diane Green, RN Kari Head, RD Betty Vivian, RN Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	F 000	*This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.* RECEIVED JUN 26 2006 FACILITY STANDARDS	
F 246 SS=D	483.15(e)(1) ACCOMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations and record review, it was	F 246	**F 246** This facility strives, to honor the right of all residents to receive, and to provide to all residents in this facility reasonable accommodation of individual needs and preferences.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 6/23/06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 1 determined that 1 of 19 (#6) sampled residents did not have a call light placed within reach. The findings include: 1. Resident #6 was admitted to the facility on 5/16/05 with diagnoses of Down's Syndrome, hypothyroidism, status post aspiration pneumonia, and sick sinus syndrome. Review of the care plan, dated 4/24/06, indicated that the resident had been identified as not being able to make needs known but was able to track objects, appeared to recognize family and was able to participate with therapies with eye hand activities. The care plan also indicated the resident received passive range of motion to bilateral upper and lower extremities, 3 to 5 days per week for 15 minutes each time. The resident required extensive assistance with all activities of daily living (ADLs). On 5/30/06 at 2:15 pm, the resident was observed to be in bed with a specially designed call light within easy reach of the resident's hands. The call light was soft, circular, and was designed to be easily activated with a slight touch. On 5/31/06 at 9:45 am, the resident was not observed to be in his room. A LN stated the resident was at a doctor's appointment. On 5/31/06 at 11:25 am, the resident was observed to be in his room, sitting up in the wheelchair. The call light was observed to be lying on the floor, next to the wheelchair. On 5/31/06, at 11:50 am, the door to the resident's room was observed to be closed. The surveyor knocked and made her presence known. After entering, the resident was observed to be in bed with full side rails in the	F 246	**SPECIFIC RESIDENT** Resident #6: Will continue to be provided a specialized call light. His care plan has been up-dated to reflect his inability to use the call light "even when available" and the need for staff to anticipate his needs. **OTHER RESIDENTS** This practice has the potential to affect all residents. Residents are provided reasonable accommodations to meet their individual needs. This includes having a call light within reach while in their rooms. **SYSTEMIC CHANGES** Staff was in-serviced on ensuring call lights are left within reach when residents are unattended in their rooms on June 13, 14, 20 and 21st 2006. **MONITORING** Unit Managers (UM) will monitor through daily floor rounds in which call light placement will be checked. Patterns of non-compliance will be taken to the monthly performance improvement meeting. Isolated non-compliance will be addressed on a 1:1 basis. Executive Director (ED) and Director of Nursing (DON) will monitor through walking rounds and the monthly (PI) meeting. **Date of Compliance July 7, 2006**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 2 elevated position and a CNA was pushing a mechanical lift towards the doorway. The CNA stated, the resident had just been transferred from the wheelchair to the bed. The call light was observed to be draped over the bedside stand and not accessible to the resident. On 5/31/06, at 12:10 pm, the room was rechecked and the call light remained draped over the bedside stand. The room was rechecked for the following times on 5/31/06: a. 12:25 pm - The call light remained draped over the bedside stand. b. 12:30 pm - A LN was observed changing the gastric tube feeding bag and restarting the tube feeding solution. The LN left the room at 12:40 pm with the call light still draped over the bedside table. c. 1:35 pm - The call light remained draped over the bedside stand. At 1:36 pm, a CNA was observed entering the resident's room. At 1:45 pm, the room was rechecked. The CNA was not in the room. The call light was observed to be draped over the bedside table. A resident who required assistance with activities of daily living did not have the specially designed call light within reach for at least 140 minutes. During that time span from 11:25 am to 1:45 pm, at least 3 different staff were observed entering the resident's room, yet the call light remained draped over the bedside table.	F 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation it was determined the facility did not ensure necessary services to maintain a sanitary and orderly interior were maintained for a 1 of 2 tub/shower rooms on Unit 2 and for one random resident's bathroom. Findings include: 1. During observations on 5/30/06 at 12:05 pm, the tub room on Unit 2 (located across from Social Services office) was noted to have a urinal in the hand washing sink. The urinal was yellow inside. The urinal was still in the sink at 4:00 pm the same day. It had been removed by 5/31/06 at 8:00 am. 2. On 5/30/06 at approximately 12:15 pm, the bathroom in room 308 was observed. The toilet had a riser seat with handles over it. The handles were wrapped in lambs wool. The left handle had a brown substance smeared on it and a splash of the brown substance was on the wall next to the toilet. At 4:00 pm, that same day, the brown substance was still observed as before. This was the case on the next day (5/31) until after lunch when the wall was observed to be wiped clean and the lambs wool handles had been removed from the toilet riser.	F 253	**F 253** This facility strives to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. **SPECIFIC** **Unit 2 Tub Room:** The urinal was removed from the Tub Room sink during survey. **Room 308 Bathroom:** The sheep skin pads with the chocolate pudding stains were removed and the wall cleaned during survey. **OTHER** This practice has the potential to affect all residents. All residents are provided the necessary services to maintain a sanitary, orderly and comfortable environment. **SYSTEMIC CHANGES** Staff was in-serviced on the importance of, and their responsibility to ensure that, the environment is kept as clean as possible, and to address soiling at the time of occurrence on June 13, 14, 20, 21, and 22nd 2006. **MONITORING** Housekeeping Supervisor will monitor through random weekly environmental sanitation checks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review it was determined the facility did not ensure a comprehensive bladder assessment was completed for 1 of 7 residents (#9) reviewed	F 272	UM will monitor through daily floor rounds. ED and DON will monitor through walking rounds and through the monthly Environment of Care meeting **Date of Compliance July 7, 2006** **F 272** This facility strives to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. **SPECIFIC RESIDENT:** **Resident #9:** Has been discharged, no correction is possible. **OTHER RESIDENTS:** This practice has the potential to affect all residents. Residents have a bladder assessment completed on admission, quarterly and as needed (PRN) changed of condition. **SYSTEMIC CHANGES:** License staff was in-serviced on ensuring the comprehensive bladder assessments are completed on June 13, & 20 2006. This includes the bladder pattern assessment if applicable.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 5 with incontinence. Findings include: Resident #9 was admitted 2/21/06 with diagnoses which included Peripheral Vascular Disease (PVD). The resident's admission MDS assessment dated, 2/28/06, indicated the resident's cognitive skills were moderately impaired mild short and long term memory problems. She required extensive assistance for all ADLS and was frequently incontinent of bladder. An initial assessment for bowel and bladder training was completed on 2/28/06. The assessment documented the resident was mildly mentally impaired and her general health was declining. The assessment indicated the resident was in a chair or bed most of the time and she sometimes made staff aware of her toileting needs. The assessment documented the resident was occasionally incontinent of bowel and had stress incontinence. The summary of the bladder assessment concluded the resident was a poor candidate for scheduled toileting or bladder retraining. Additionally, the facility completed a "Urinary Incontinence Assessment," dated 5/9/06. The assessment documented the resident had stress incontinence with reaching and changing position and had a history of urinary tract infections. The resident required assistance in the bathroom but could comprehend and follow directions and recognized the urinary urge sensation. The form then instructed staff to perform a 3 - day "Bladder Pattern Assessment" to assist with the choice of a program. There was no documented evidence the	F 272	**MONITORING:** The IDT will monitor through review of the bladder assessments utilizing the same schedule as the MDS. MDS nurse will monitor through review of the completed paperwork during completion of the MDS. ED and DON will monitor through the monthly PI and Standards of Care Committee meeting. **Date of Compliance July 7, 2006**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 6 three day "Bladder Pattern Assessment," had been completed prior to the resident being assigned a prompted voiding program and a check and change program. The care plan, dated 3/3/06, documented the resident had a self care deficit and was to be toileted upon rising, before and after meals, Q [every] HS [hours of sleep], PRN [as necessary] per resident request and Q four hours at night. There was no indication the facility worked out an individualized toileting schedule with the resident. On 5/31/06 at 6:45 am the resident was observed sitting in a wheelchair adjacent to the nursing station. The resident was taken to the dining room at 7:30 am and her breakfast tray was served at 8:10 am. At 9:10 am the resident was sitting in a wheelchair in the doorway of her room. At 9:40 am she was observed in a recliner in her room. The resident stated,"I am hurting," pointing to the genital area, and stated she needed to go to the bathroom. The licensed nurse stated "She was just put in her recliner five minutes ago." When the LPN and CNA placed the resident on the toilet at that time her briefs were wet. Lack of a complete assessment resulted in a care plan that was not individualized and did not meet the resident's needs to maintain continence.	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews it was determined the facility did not ensure the accuracy of MDS coding. This affected 4 of 19 sampled residents (#4, 5, 8, &16). The findings include: 1. Resident #5 was admitted to the facility on	F 278	**F 278** This facility strives to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity coordinated by a Registered Nurse and signed by the participating clinical professionals. **SPECIFIC RESIDENT** **Resident #5:** MDS has been signed by the RN assessment Coordinator **Resident #4:** MDS has been modified to accurately reflect the use of side rails for mobility. **Resident #8:** MDS has been modified to accurately reflect the use of side rails for mobility. **Resident #16:** Has been discharged from this facility. However, if the red area blanched it is not a pressure area and should not be coded on the MDS as one. **OTHER RESIDENTS:** This practice has the potential to affect all residents. Residents have the MDS accurately code to reflect their condition at the time of the assessment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 8 11/11/05 with diagnoses which included a history of after care for a fracture of the right humorous, Alzheimer's type dementia. Review of the resident's record revealed a quarterly review MDS assessment with an assessment reference date of 4/29/06. Review of section "R2.a. Signature of RN Assessment Coordinator (sign on above line)" revealed that it was left blank. The section "R2.b. Date RN Assessment Coordinator signed as complete" was also left blank. On 6/1/06 at 1:45 pm, the facility's MDS Coordinator was interviewed. The MDS Coordinator stated the MDS assessment located in the resident's record should have been signed and dated as being completed. She stated that it was an oversight. 2. Resident #4 was readmitted to the facility on 10/27/05 with the diagnoses of diabetes mellitus, neuropathy, venous insufficiency, hypertension, degenerative joint disorder, recurrent urinary tract infection, dysphagia and depression. The resident's most recent quarterly MDS, dated 5/1/06, documented under G6: Modes of Transfer, "bed rails used for bed mobility or transfer." This assessment also documented under P4: Devices and Restraints, "other types of side rails used (e.g. half rail, one side)." This indicated that the side rails used for this resident were assisting the resident with bed mobility and restraining the resident. Resident #4's Physician's Recapitulation (recap) orders documented, "Adjustable high/low bed w/ [with] 1/4 SR [side rail] X [times] 2 to assist	F 278	**SYSTEMIC CHANGES:** Staff involved in the RAI Process was in-serviced on accurately coding the MDS on June 13, & 20 2006. The coding of restraints will be reviewed during the care plan conference to ensure no errors. **MONITORING** Restorative Nurse or MDS nurse will monitor through review of section G6 and P4 of the MDS during care plan conference. **Date of Compliance July 7, 2006**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 9 w/proper ht [height] for trfr [transfer] [and] allow res[ident] to I [independently] assist w/bed mob [mobility]." On 5/30/06 at 1:15 pm, resident #4 was observed siting in wheelchair in her room next to her bed. The bed was observed to have two transfer/mobility canes on her bed. The resident indicated she used those devices to help her turn in bed and to get in and out of bed. On 6/1/06 at 12:30 pm, the MDS nurse was interviewed and acknowledged that resident #4 had two small mobility devices on her bed and that these devices were not restraints. The MDS nurse also acknowledged that these mobility devices were incorrectly coded on the resident's 5/1/06 MDS, when they were also coded in the P4 or restraint section. 3. Resident #8 was readmitted to the facility on 10/25/05 from the hospital with a left below the knee amputation diagnosis. Other diagnoses included: diabetes, congestive heart failure, hypertension, restless leg syndrome, increased lipids, and mitral valve stenosis. Review of the quarterly MDS, dated 4/23/06, under Section G6, Modes of Transfer, revealed the box was checked for "b. Bed rails used for bed mobility or transfer." On the same MDS report under P4, Devices and Restraints, under "Bed rails, b.- Other types of side rails used (e.g., half rail, one side)" the number 2 (Used daily), had been assigned. Review of the assessment form dated 1/12/06, "Review for Continuation of Restraints or	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 10	F 278		

Supportive Device," documented that the device was used as an adjustable, 1/4 side rail x2. The assessment form also indicated "no restraint - used for proper ht (height) with transfers. The device benefits the resident by providing bed mobility."

The "Physical Restraint & Supportive Device Assessment & Plan" report, dated 5/23/06, revealed that, " because of the resident's short stature, the resident has been given a hi-low bed with transfer handles to allow the resident to actively participate in transfers and bed mobility."

On 5/31/06 at approximately 7:30 am, resident #8 was interviewed. The resident was asked if the short side rails ever inhibited her movement. The resident stated, "No, they don't, they're really handy."

During observations of the resident's care, on 6/01/06 at 1:00 pm., the surveyor noted that the resident used her 1/4 side rails to move and turn in bed, and with some assist from the CNA, the resident was also able to sit up to the side of the bed. The CNA stated,"she does a real good job with those hand rails." The resident then stated, "Oh yes, I really like them."

The resident used the side rails as a mode of transfer, rather than as a restraint which was indicated on the MDS.

4. Resident #16 was admitted to the facility on 5/18/06 with a diagnoses of quadriplegia secondary to cervical spine compromise due to cervical disk disease.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 11 Review of the nursing assessment, dated 5/18/06, indicated the resident had a 1 centimeter reddened area. On the assessment form, was a line from the statement, "1 cm reddened area closed," leading to a circle that had been placed at the coccyx area of a human drawing. The treatment sheet for the weekly skin at risk checks stated, "5/24/06, 2200 [10:00 pm] Pt [patient] has 1 cm size redden [sic] area at sacral bone. Not open. Blanches < [less than] 4 sec[ond]. Turned side to side. Small bruises noted to arms. [No] other issues noted." There was no documentation to indicate the 1 cm red area at the sacral bone was a stage 1 pressure sore. The admission MDS, with an assessment date of 5/25/06, indicated the resident had no pressure ulcers.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interview it was determined the facility did not ensure residents' comprehensive care plans were revised to reflect the current needs of each resident. This was true for 3 of 22 sampled residents (#'s 1, 9 and 11). Findings include: 1. Resident #11 was admitted to the facility on 12/5/05 with the diagnoses of cranial cervical meningioma, quadripareses, respiratory failure, diabetes mellitus, tracheostomy, and depression. The resident's Physician Recapitulation (RECAP) orders for May 2006, documented the following diet order, "NPO [nothing by mouth] - See tube	F 280	**F 280** This facility utilizes a comprehensive care planning process involving input from the interdisciplinary team members, residents and their families to determine and communicate individual care needs of each resident to caregivers. **SPECIFIC RESIDENT** **Resident #1: C**are plan has been up-dated to include specific directions for when to provide catheter care. **Resident #9:** Has been discharged from this facility with skin intact; no correction is possible. **Resident #11:** Care plan has been updated to appropriately reflect this resident's status. **OTHER RESIDENTS:** This practice has the potential to affect all residents. Residents' care plans are revised quarterly and PRN change in current status. **SYSTEMIC CHANGES:** Residents care plans are reviewed with each change of status, significant care events, and no less frequently than quarterly in the facility's Standards of Care committee. All licensed staff, including those involved in the RAI process was in-serviced on reviewing and up-dating care plans on June 13 & 20 2006.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 13 feeding. H2O [water] thin between meals 1 hr [hour] AC or PC [before or after]. There was a faxed physician order, dated 5/23/06, that documented, "mech [mechanical] soft diet / honey thick liquids." Resident #11's comprehensive care plan, dated 3/16/06, documented a problem of "alteration in nutrition: Feeding Tube R/T [related to] NPO D/T [due to] trach." The approaches to this problem included, "1) change peg tube as ordered, 2) elevate head of bed 30 degrees during feeding and 30 minutes after feeding, 3) feeding solution per current MD [physician] orders, 4) monitor weight weekly x [times] 4 then monthly, 5) change drsg [dressing] and site care per current MD order and house protocol, 6) lunch trials [with] SLP [speech language pathologist]." There was no care plan update instructions documented to direct staff how to assist the resident in feeding since her diet order was advanced. On 6/1/06 at 12:30 pm, the LN responsible for MDS and care planning was interviewed. She acknowledged the resident's care plan had not been updated since her diet advancement. The LN indicated that speech therapy should have documented instructions on the temporary care plan update form and would look into the matter with them. At 4:05 pm, the LN returned and indicated that the speech department acknowledged a temporary care plan update related to the diet advancement had not been done and should have.	F 280	**MONITORING:** UM will monitor through random weekly care plan audits until compliance is achieved. MDS nurse will monitor through review of the care plans during care plan conferences. DON will monitor through review of the care plan audits and participation in the monthly PI meeting. **Date of Compliance July 7, 2006**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 14 2. Resident #9 was admitted 2/21/06 with diagnoses which included Peripheral Vascular Disease (PVD). The resident's admission MDS assessment, dated 2/28/06, indicated cognitive skills were moderately impaired and the resident had mild short and long term memory problems. She required extensive assistance with all ADLS, frequently incontinent of bladder and had no pressure ulcers at the time of assessment. The resident's care plan, dated 3/9/06, documented the following: a) "At high risk for impaired skin integrity R/T [related to] decreased sensation R/T DX [diagnosis] of Peripheral Neuropathy and PVD ...ability to walk is severely limited and she spends most of her time in bed or chair. The short term goal was to, "Have skin issues addressed in a timely manner as they arise." The approaches identified included: a) "Special protective mattress used." b) "Roho cushion in wheelchair" c) "Will evaluate weekly with daily heel, coccyx and perineal area." d) "Foam heel lift boots at night, remove and monitor skin integrity. Bridge heels if resident refuses." e) "Foot cradle to end of bed to keep pressure off of feet ..." Nursing notes, dated 5/27, 5/28, 5/29 and 5/30/06, documented the resident had red heels and the staff monitored the problem. Nursing notes, dated 5/30/06, documented the problem	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 15 was resolved. There was no documentation in these notes to indicate interventions that were in place other than foam boots that were to be worn at night. On 5/31/06 at 12:30 pm the resident was observed being assisted to eat. She had on protective boots that were not made of foam on both feet. On 6/1/06 at 9:40 am, the resident was observed sitting in her wheelchair with walking shoes on both feet. The Unit Manager removed the resident's shoes and socks so the resident's feet could be observed. The left heel was slightly discolored, appeared soft and to have fluid under the skin on the heel. The right heel appeared soft and had more fluid under the skin than the left heel. The posterior aspect of the right foot near the bottom of the foot had a reddened area approximately 3 cm long and 1 cm wide. On 6/1/06 at 9:40 am the Unit Manager stated, "She wears the foam boots all the time and the resident stated "No, I only wear them at night." On 6/1/06 at 9:40 am, the CNA stated she had put the resident's walking shoes on her in the morning as she did not know the resident was not to wear the shoes. During observation of resident care on 6/1/06 at 9:40 am, it was noted the resident had a pair of foam boots and another pair of special boots in her closet. The CNA placed the non foam boots on the resident, the left boot fit properly keeping the heel floated, the right boot was constructed	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 16	F 280		

differently and the right heel fit directly on a hard surface of the boot without providing protection from pressure.

The care plan had not been updated based on an accurate assessment of the resident's skin problems. The plan did not include specific direction to staff as to what measures were to be used to prevent pressure to the resident's feet. This resulted in failure to provide consistent effective care to prevent pressure sores.

3. Resident #1 was admitted to the facility on 1/14/06 with diagnoses of chronic obstructive pulmonary disease, anemia and osteoporosis.

Nurse progress notes, dated 4/13/06 (7:45 pm), documented "...Suprapubic intact. DSG [Dressing] intact [with] [no] drainage or s/s [signs/symptoms] of infection..."

The care plan dated 4/25/06, documented identified problem (13), "Alteration in bladder function: Utilizes suprapubic catheter..." Approaches included, "Change suprapubic catheter [every] month and then prn [as needed] (plugging or displacement) and per current MD order...Monitor placement of cath tubing; ensure optimal drainage as able. Monitor for s/sx [signs/symptoms] of UTI [urinary tract infection]...Suprapubic cath care per facility policy..."

The policy for "Daily Suprapubic Catheter Care" was not dated. While the policy contained information regarding procedure and techniques for cleaning and care of the catheter there were no directives for how often staff should clean the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 17 catheter. The care plan had not been revised to include all directives to staff for resident #1's suprapubic catheter care. Treatment sheets for the month of April 2006 documented "Suprapubic Cath[eter] care [every] shift." Documentation indicated the resident received the care only on the day shift. For May 2006 treatment sheets documented, "Suprapubic Cath care [every] shift." Catheter care was documented as completed on every shift. The care plan did not give direction as to how many times a day the suprapubic catheter site needed to be cleaned.	F 280		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interview, it was determined that the facility did not follow the physician orders and care plan and utilize compression stockings and a prafo boot for 1 of 22 sampled residents (#16) whose care plans were reviewed. The findings include: 1. Resident #16 was admitted to the facility on	F 309	**F 309** This facility strives to provide all of the necessary care and services required by each resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and care plan. **SPECIFIC RESIDENT** **Resident #16:** Has been discharged from this facility with skin intact; no correction is possible. **OTHER RESIDENTS:** This practice has the potential to affect all residents. All physician ordered equipment is utilized as ordered and care planned. This	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 18 5/18/06 with a diagnoses of quadriplegia secondary to cervical spine compromise due to cervical disk disease. The admission orders, dated 5/18/06, indicated the resident was to have TED hose on during the day and off in the evenings. The "Routine Nursing Standing Orders/Care Plan," dated 5/18/06, indicated the resident was on edema checks and utilized a prafo boot to minimize foot drop. On 6/01/06 at 1:05 pm, the resident was observed to be sitting in a wheelchair. The resident was wearing a pair of pink colored stockings and was not wearing the TED [a compression stocking] hose. At 2:00 pm, the resident was observed sitting in the same position in the wheelchair with the pink stockings and no TED stockings. On 6/01/06 at 2:05 pm, the LN checked the resident's feet and heels. When the pink colored stockings were removed, it was observed that both ankles had a circle of constriction matching with the elastic topping of the stockings. The depth of the constrictions were approximately 2 millimeters. The LN explained the resident had problems with edema and usually wore TED stockings every day. The LN stated, "We couldn't find any today." As the LN was examining the constricted areas of both ankles, she stated to the resident, "We need to get you some TEDs. These [indicating the pink stockings] aren't the best socks for you." Before leaving the room to get the TEDS, the LN explained to the surveyor that the prafo boots would be put on when the resident	F 309	includes Ted Hose and specialized boots. **SYSTEMIC CHANGES:** Licensed staff was in-serviced on the need to implement and follow all physician orders and the care plan on June 13 & 20 2006. Direct Care staff was in-serviced on ensuring adaptive equipment is in place as needed on June 13, 14, 20 and 21st 2006. **MONITORING:** UM and floor nurses will monitor through daily floor rounds checking for placement of equipment. DON will monitor through random weekly floor audits of equipment placement. ED will monitor through participation in the monthly PI meeting. **Date of Compliance July 7, 2006**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 19 was in bed. On 6/01/06 at 3:10 pm, the resident was observed in bed with heels lying flat on the mattress. The prafo boots had not been put on the resident. The left foot was in the dropped foot position. The right foot was lying at an angle and was dropping but not as extreme as the left foot. The resident was wearing TED hose and had the pink colored stockings placed on both feet. The resident was rechecked at 3:35 pm, 3:55 pm, 4:30 pm, and at 5:05 pm. The prafo boots remained off, the feet were in the dropped foot position and the pink stockings, which had already constricted the resident's ankles, remained in place, over the TED hose.	F 309		
F 314 SS=E	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and record review, it was determined the facility did not ensure consistent preventive measures were implemented for residents at risk for developing pressure ulcers. The facility also failed	F 314	**F 314** This facility strives to ensure, to the extent possible, that any resident who enters the facility without pressure sores does not develop pressure sores, and that all resident admitting with pressure sores receive the appropriate care and treatment to promote healing and prevent infection to the extent possible. **SPECIFIC RESIDENT** **Resident #18:** Skin continues to be intact. Her skin is assessed weekly by licensed staff and monitored daily during cares by floor staff. Preventive measures are consistently implemented as care planned.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 20 to ensure ongoing complete and measurable documentation of current pressure ulcers. This was true for 9 of 19 sampled residents (#'s 5, 6, 7, 9, 12, 14, 16, 18, and 19). The findings include: 1. Resident #18 was admitted to the facility on 3/31/06 with diagnoses which included pain, failure to thrive, history of fracture of the right lower ribs, rheumatoid arthritis, chronic urinary incontinence, anemia, contractures to the knees bilaterally, and compression fractures. According to the resident's admission MDS assessment, dated 4/6/06, the resident was moderately impaired with cognitive skills for daily decision making and required extensive assistance of one staff member for bed mobility and limited assistance of one staff member for transfers. The assessment also indicated the resident was admitted with two stage I pressure ulcers to the resident's heels. Further review of the resident's record revealed a "Braden Scale for Predicting Pressure Sore Risk," with an assessment date of 3/31/06, which indicated the resident was at moderate risk for a pressure ulcer with a total score of 14. The resident was assessed again on 4/19/06, which indicated the resident was at risk for a pressure ulcer with a total score of 17. Review of the resident's plan of care, updated 5/22/06, revealed a problem of, "At risk for alteration in skin-integrity r/t [related to] admitted with reddened bilat [bilateral] heels, excoriation to bottom..." The documented approaches included the following: "...(2) Observe skin daily and report any broken areas to nurse; encourage [resident's	F 314	**Resident #9:** Was discharged with skin intact, no correction is possible. **Resident #6:** Skin continues to be intact. His skin is assessed weekly by licensed staff and monitored daily during cares by floor staff. Preventive measures are consistently implemented as care planned. **Resident #16:** Was discharged from this facility with skin intact. **Resident #7:** Skin continues to be intact. Her skin is assessed weekly by licensed staff and monitored daily during cares by floor staff. Preventive measures are consistently implemented as care planned. **Resident #12:** Skin continues to be intact. Her skin is assessed weekly by licensed staff and monitored daily during cares by floor staff. Preventive measures are consistently implemented as care planned. **Resident #'s 5, 14 and 19:** Skin continues to be intact. Their skin is assessed weekly by licensed staff and monitored daily during cares by floor staff. Preventive measures are consistently implemented as care planned.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 21 name] to turn and redistribute pressure q [every] 2 hours or more frequently, may need staff assist at times; (3) LN will evaluate weekly...(9) Foam heel lift boots while in bed remove q shift & [and] [check] skin Bridge heels if refuses." Review of the resident's record revealed treatment flowsheets for the months of April and May 2006 on which it was documented, "SAR [skin at risk] q [every] week: Doc [document] (+) if problem/chart on back. Doc (-) if no problem." On 4/2/06, it was documented, "Red bilateral heels, Red peri-rectal area." On 4/4/06, 4/11/06, and 4/18/06, a "-" sign was documented. On 4/25/06, a "+" sign documented. On the back of the form it was further documented, "Bilateral heels et [and] buttocks slightly red." Review of the May 2006 SAR flowsheet revealed no further documentation about the resident's reddened heels. No further documentation could be located to indicate the facility had ongoing assessments of the pressure ulcers to indicate the stage of the ulcers or other characteristics of the ulcers, such as measurements, if the reddened areas were blanchable, or if the current care planned approaches were effective in the treatment of the pressure ulcers. Observation of the resident on 6/1/06 at 1:30 pm, revealed the resident in bed, laying on her back and her heels laying directly on the mattress. No foam heel lift boots were observed on the resident's feet. At that time, a contract hospice nurse was in the resident's room. The hospice nurse was asked to assist the surveyor in observing the resident's heels. Upon removal of the resident's socks, the resident stated both of her heels were sore to touch. Observation of the	F 314	**OTHER RESIDENTS:** This practice has the potential to affect all residents. All residents who are at risk for skin breakdown have preventive measures consistently implemented as care planned. Residents' with wounds have complete measurements and condition of wounds documented in the medical record. **SYSTEMIC CHANGES** Staff was in-serviced on skin prevention programs, assessment, wound documentation and following the care plan on June 13, 14, 20 and 21st 2006. Floor nurses monitor for equipment placement and preventive measures during daily floor rounds. A new skin assessment sheet has been implemented to provide more accurate documentation of skin condition. **MONITORING:** UM will monitor through participation in the weekly Standards of Care (SOC) meeting. Restorative will monitor through weekly skin rounds. ED and DON will monitor through participation in the monthly PI meeting. **Date of Compliance July 7, 2006**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 22 resident's left heel revealed a dark reddened area approximately a quarter size on the outer aspect of the resident's heel. The hospice nurse also acknowledged the resident's heel was reddened, and the resident's heels needed to be floated. She stated this was only her third time visiting the resident, and she was not sure if the heels had been floated in the past visits. On 6/1/06 at 1:45 pm, a LN was interviewed regarding the documentation on the SAR flowsheets. The LN stated the LNs are to document a (-) or a (+) sign and if (+), the LN was to document on the back of the form. She stated it was the facility's policy not to measure the affected skin areas unless they were open areas. According to federal guidance for F314, the facility needs to accurately and consistently assess a resident's skin integrity on admission and as indicated. Included in the monitoring and assessment of a current skin ulcer, it was important to, "Differentiate the type of ulcer...; determine the ulcer's stage; describe and monitor the ulcer's characteristics; monitor the progress toward healing and for potential complications..." 2. Resident #9 was admitted 2/21/06 with diagnoses which included Peripheral Vascular Disease (PVD). The resident's admission MDS assessment dated 2/28/06 indicated cognitive skills were moderately impaired and the resident had mild short and long term memory problems. The resident required extensive assistance with all ADLS, was frequently incontinent of bladder and had no pressure ulcers at the time of assessment.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 23 The resident's care plan, dated 3/9/06, documented the following: a) "At high risk for impaired skin integrity R/T [related to] decreased sensation R/T DX [diagnosis] of Peripheral Neuropathy and PVD ...ability to walk is severely limited and she spends most of her time in bed or chair. The short term goal was, "Have skin issues addressed in a timely manner as they arise." The approaches identified included: a) "Special protective mattress used." b) "Roho cushion in wheelchair." c) "Will evaluate weekly with daily heel, coccyx and perineal area." d) "Foam heel lift boots at night, remove and monitor skin integrity. Bridge heels if resident refuses." e) "Foot cradle to end of bed to keep pressure off of feet ..." Nursing notes, dated 5/27/06, documented,"Res [resident's] daughter noticed the resident's heels B[bilaterally] are red and there are red areas to B shins - Res has foam booties placed to B feet. Dr faxed. - Res placed on alert charting to monitor areas to BLE [bilateral lower extremities]." Nursing notes, dated 5/28/06, documented, "Res. cont[inues] to be monitored for B heels red areas ... no s/s [signs and symptoms] of areas worsening." Nursing notes, dated 5/29/06, documented, "Foam boots placed while resident in bed for bil [bilateral] heel redness and possible skin	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 24 breakdown." Nursing notes, dated 5/30/06, documented, "No redness, area intact, firm, resolved." On 5/31/06 at 6:45 am the resident was observed sitting in a wheelchair adjacent to the nursing station with foam boots on both feet. She was observed at 7:30 until 8:10 am, in the dining room with the same foam boots on both feet. The resident was observed on 5/31/06 at 12:30 pm in the dining room. She had on protective boots that were not made of foam on both feet. On 6/1/06 at 9:10 am the resident was sitting in a wheelchair in the doorway of her room with walking shoes on both feet. On 6/1/06 at 9:40 am, the resident was observed sitting in her wheelchair with walking shoes on both feet. The therapist was in the room with the resident measuring her for a wheelchair. At 9:45 am, the Unit Manager removed the resident's shoes and socks so the resident's feet could be observed by the surveyor. The left heel was slightly discolored, appeared soft and to have fluid under the skin on the heel. The right heel appeared soft and had more fluid under the skin than the left heel. The posterior aspect of the right foot near the bottom of the foot had a reddened area approximately 3 cm long and 1 cm wide. The Unit Manager stated, "She wears the foam boots all the time and the resident stated "No, I only wear them at night." A CNA came into the room and the Unit Manager asked the CNA to replace the resident's socks and put protective boots in place. The CNA stated she had put the	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 25 resident's walking shoes on her in the morning as she did not know the resident was not to wear the shoes. During observation of resident care on 6/1/06 at 9:45 am it was noted the resident had a pair of foam boots and another pair of special boots in her closet. The CNA placed the non-foam boots on the resident. The left boot fit properly keeping the heel floated; the right boot was constructed differently and the right heel fit directly on a hard surface of the boot and did not float the heel. The CNA stated the boot on the right foot appeared to have been modified The RN Unit Manager stated she thought the daughter had brought in one of the boots and she did not know why one boot was different from the other. She stated the therapy department provided the special boots to prevent pressure on the heels. She stated she would have the wound nurse evaluate the residents's feet and follow her recommendations. A complete assessment of the resident's heels and feet was not found in the medical record. The care plan had not been updated to clearly direct staff as to what protective measures to implement and when they were to be implemented. This resulted in lack of consistent measures being used to prevent pressure to the heels. 3. Resident #6 was admitted to the facility on 5/16/05 with diagnoses of Down's Syndrome, hypothyroidism, status post aspiration pneumonia, and sick sinus syndrome. The care plan dated 4/24/06, indicated the	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 26 resident had been identified as having an "alteration in skin integrity." The onset of the problem was 5/16/05. One approach to the problem stated, "(7) Foam heel lift boots while in bed..." The annual MDS for the assessment reference date of 4/24/06, indicated the resident received preventative or protective foot care. The "Braden Scale for Predicting Pressure Sore Risk," with an assessment date of 4/26/06, indicated the resident was at moderate risk for a pressure ulcer with a total score of 13. On 5/31/06, the resident was observed several times, in bed without the foam heel/foot lift boots. The resident was observed, in bed with heels on the mattress at the following times on 5/31/06: a. 6:55 am. b. 7:15 am. c. 7:35 am. d. 8:40 am. e. 9:15 am. f. 11:50 am- The door to the resident's room was observed to be closed. The surveyor knocked and made her presence known. After entering, the resident was observed to be in bed with full side rails in the elevated position and a CNA was pushing a mechanical lift towards the doorway. The CNA stated, the resident had just been transferred from the wheelchair to the bed. The CNA left the room with the mechanical lift. The resident's heels were observed to be resting on the mattress. g. 12:10 pm. h. 12:25 pm.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 27 i. 12:30 pm - A LN was observed changing the gastric tube feeding bag and restarting the tube feeding solution. The LN left the room at 12:40 pm. The resident's feet remained resting on the mattress without the foam heel/foot lift boots in use. j. 1:35 pm. A resident at risk for heel breakdown did not have heel protectors applied when in bed. 4. Resident #16 was admitted to the facility on 5/18/06 with a diagnoses of quadriplegia secondary to cervical spine compromise due to cervical disk disease. Review of the nursing assessment, dated 5/18/06, indicated the resident had a 1 centimeter reddened area. On the assessment form, was a line from the statement, "1 cm reddened area closed," leading to a circle that had been placed at the coccyx area of a human drawing. The "Braden Scale for Predicting Pressure Sore Risk," dated 5/18/06, indicated the resident was a very high risk for pressure sores with a score of 9. The assessment tool indicated the resident had hemiplegia, a history of pressure ulcers, an existing pressure ulcer, decreased or impaired bed/chair mobility, urinary or bowel incontinence and was febrile. The comment section stated, "air mattress...turn q [every] 2 [hours]...bridge heels off bed..." The initial nursing care plan, dated 5/18/06, indicated the resident had been care planned to have the heels bridged while in bed due to the identified problem of being at high risk for the	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 28	F 314		

development of pressure sores. The initial nursing care plan also indicated the resident would have daily coccyx and heel checks related to the "high risk for skin breakdown."

The May 2005 treatment sheet stated, "TX [treatment] Daily coccyx, heel checks R/T [related to] high risk for skin breakdown." The word "Info [information]" had been hand written in the time section of the form. There were no initials to indicate staff had completed the daily heel and coccyx checks.

The treatment sheet for the weekly skin at risk checks stated, "5/24/06, 2200 [10:00 pm] Pt [patient] has 1 cm size redden [sic] area at sacral bone. Not open. Blanches < [less than] 4 sec[ond]. Turned side to side. Small bruises noted to arms. [No] other issues noted." There was no documentation to indicate the 1 cm red area at the sacral bone was a stage 1 pressure sore.

On 6/01/06 at 1:05 pm, the resident was observed to be sitting in a wheelchair with a padded seat cushion with feet resting flat on the solid surface of the wheelchair foot pedal. The resident was not wearing shoes but was wearing a pair of pink colored stockings. At 2:00 pm, the resident was observed sitting in the same position in the wheelchair with stocking feet resting solidly on the wheelchair foot pedal.

At 2:05 pm on 6/01/06, the LN checked both heels. When the pink colored stockings were removed, it was observed that both ankles had a circle of constriction matching with the elastic topping of the stockings. The depth of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 29	F 314		

constrictions were approximately 2 millimeters. The LN stated, "...These aren't the best socks for you." The heels had no areas of redness.

At 3:10 pm on 6/01/06, the resident was observed in bed with heels lying flat on the mattress. The resident was wearing TED [a compression stocking] hose and had the pink colored stockings, which had constricted the ankles, on both feet. The resident was rechecked at 3:35 pm, 3:55 pm, 4:30 pm, and at 5:05 pm. Both heels remained flat on the mattress and the pink stockings remained in place, over the TED hose.

On 6/01/06 at approximately 2:00 pm, the Unit Manager LN was interviewed concerning the documentation of the daily heel and coccyx checks. The LN stated, "The daily checks are not normally documented. The staff does them but we don't sign off on the treatment sheet...that's for information only." The Unit Manager indicated that the weekly skin at risk checks were documented on a treatment sheet and offered to find the documentation. The Unit Manager also indicated that the red area on the coccyx was healing.

A resident at risk for pressure sores and admitted with a 1 cm. red area on coccyx, did not have the daily checks for the heels and coccyx documented. In addition, the resident had both feet resting on wheelchair footrests while wearing stockings that constricted the ankles, impairing blood flow to the feet. After being transferred to bed, the stockings causing the ankle constrictions, were reapplied over a pair of compression stockings and the heels were not bridged off the mattress.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 30	F 314		

5. Resident #7 was admitted to the facility on 12/28/05 with diagnoses of dysphagia, chronic atrial fibrillation, failure to thrive and leukemia. The resident had been receiving contracted hospice care since 3/16/06.

The care plan, dated 3/04/06, indicated the resident had been identified as being at risk for alteration in skin integrity. The onset date was 10/28/05. One of the approaches to the problem stated, "(1) Special protective devices used:...bridge heels while in bed."

The significant change MDS for assessment reference date of 3/04/06, indicated the resident was 63 inches tall and weighed 98 pounds and had a pressure ulcer which had resolved in the last 90 days. The MDS indicated the resident had pressure relieving devices for the bed and chair.

The "Braden Scale for Predicting Pressure Sore Risk," indicated the resident was at moderate risk for a pressure sore with a score of 14.

At 10:15 am on 5/30/06, the resident's bilateral lower extremities were checked by a LN. The LN checked the legs for pitting edema and stated the resident had 2 plus edema on the right leg and 1 plus on the left leg. The LN explained the resident had problems with weeping sores on both lower legs but they were healing. The heels of both feet were observed to have loose, hanging skin. The color was pale, gray/white. Overall the resident had very little body fat and both feet had ankle, heel and the bones on the lateral side of the foot protruding. The LN stated, "They [meaning the heels] don't feel boggy."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 31 The resident was observed on the following dates and time with both feet lying flat on the mattress without being bridged on a pillow. A pillow was observed sitting in a chair next to the bed during those observations: a. 5/31/06 at 1:35 pm and at 2:45 pm. b. 6/01/06 at 9:40 am. A resident at risk for pressure sores to the feet/heels did not have the heels bridged while in bed. 6. Resident #12 was admitted to the facility on 12/5/05 with diagnoses that included after care for a fractured hip, decubitus ulcer/lower back, history of falls, depressive disorder and anxiety state. The admission MDS, dated 12/11/05, documented the resident as moderately cognitively impaired with short term memory loss. The same MDS also confirmed the resident had a Stage II pressure sore, needed extensive assistance for transfers and was frequently incontinent of bladder. A RAP triggered for pressure sores and documented, "Res[ident] with sacral decubitus on admit...Res on air mattress. Proceed to care plan." The current quarterly MDS, dated 3/4/06, documented the resident still needed extensive assistance to transfer and was usually continent of bowel. Her cognition had improved to modified independence but short term memory loss was still a problem and she was occasionally incontinent of bladder and had a catheter. (A nurse quarterly review note, dated 3/6/06, documented the resident had a Foley	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 32	F 314		

catheter which had a few episodes of leaking during the assessment period). A Braden Scale risk assessment, dated 3/6/06, documented the resident was at moderate risk for pressure sores.

The resident's care plan, dated 3/4/06, identified problem (6) "Risk for alteration in skin integrity R/T [related to] HX [history] of excoriation to coccyx." Goal: "[Resident #12] will have skin issues addressed in a timely manner as they arise thru: Approaches, Special protective devices used air mattress with side rails x 2 per manufacturer's recommendation and cushion to w/c [wheel chair]. Observe skin daily and report any broken areas to nurse; position off wound, turn and redistribute pressure Q [every] 2 hours or more frequently. LN will evaluate weekly...Minimize exposure to moisture and keep skin clean, especially of fecal contamination. Maintain or improve nutrition and hydration status, where feasible..."

The resident was observed on 5/30/06 at 11:35 am, 12:00 pm, 2:20 pm, 3:05 pm and 3:50 pm. She was sitting in her room in her wheelchair (which had a protective pad) for all these observations. She was usually asleep with her head hanging down towards her chest. On 5/31 the resident was observed at 8:30 am sitting in her wheel chair. She was being assisted by an aide to wash her face. At 9:10 am she was sitting in her wheelchair and an another aide was assisting her with her make-up. At 11:00 am she was seated in her wheelchair watching T.V. The resident was asked if she would sit in a recliner if she had one in her room. She said, "It would be nice." The resident also indicated to the surveyor that she did not like to leave her room. She was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 33	F 314		

observed again at 1:40 pm, seated in her w/c and still eating her lunch. For all these observations the w/c was between the bed and the privacy curtain which was usually pulled between the resident and her roommate. The opposite side of the resident's bed was next to the window and there were two chairs for (one in each corner) placed there. One of the chairs was filled with folded blankets and other linen. They were straight back chairs with wooden arm rests. The chairs would not have reclined or offered a different seating position than the w/c did.

The Unit Manager LN was interviewed on 5/31/06 at 1:45 pm. She said the resident would not get out of bed after she was admitted and now she does not like to get out of her chair. The surveyor asked if they had ever considered a recliner or geri-chair in the resident's room so at times she could be tilted back and reduce the pressure on her buttocks and coccyx. The LN said, "We could certainly get her a recliner."

The resident was observed on 6/1/06 at 9:45 am, seated in her wheel chair next to her bed. She was again observed at 12:30 pm, asleep in the wheelchair next to her bed.

The resident had a previous pressure sore to her coccyx. She was not receiving positioning redistribution of pressure to her buttocks and coccyx often enough, to decrease the potential for pressure sores. The care plan did not have alternatives in place for the resident, who wanted to sit up all day in her wheel chair, once she awakened and got up for the day.

7. Similar findings were determined for residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 34 #5, #14 and #19 during the annual recertification survey of 6/2/06. This is a repeat deficiency from the annual recertification survey of 5/1/05.	F 314		
F 322 SS=D	483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, it was determined that the facility did not ensure appropriate care of an enteral feeding tube when the tube was not checked for placement and the feeding was not adjusted to accommodate changes in activity and occupational therapy needs. This affected 1 of 3 (#6) sampled residents evaluated for enteral tube feeding. The findings include: 1. Resident #6 was admitted to the facility on 5/16/05 with diagnoses of Down's Syndrome, hypothyroidism, status post aspiration pneumonia, and sick sinus syndrome. The recapitulated physician orders for May 2006 stated, "Enteral nutrition flow sheet - Formula	F 322	**F 322** This facility strives to ensure that any resident who is fed by a naso-gastric tube or a gastrostomy tube receives appropriate treatment and services to prevent related complications. **SPECIFIC RESIDENT** **Resident #6:** Continues to have no complications from enteral feedings. He has gradually gain weight and is nutritionally stable. New orders for tube feedings have been obtained to allow more freedom of movement and easier participation in activities and therapies. Placement of the tube is checked prior to administration of medications or feeding solution. **OTHER RESIDENTS:** This practice has the potential to affect all residents utilizing enteral feedings. Residents who require enteral feedings receive services that meet basic nursing standards. This includes checking placement of tube prior to administration of feedings and ensuring the feedings are administered as ordered.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 35 type: Jevity 1.2 cal [calories] NPO [nothing by mouth]: Yes. Pump: at the rate of 70 cc/hr [cubic centimeters per hour] continuous pump over 24 hrs. 1680 total cc's at 2016 calories 24 hours...Tube type: PEG [percutaneous endoscopic gastrostomy]. May crush meds or use liquid form via tube. Check tube placement prior to each use and doc [document]: (+) appropriate (-) repositioned...Check residual before each feeding..." The physician orders indicated the PEG feeding tube had been started 5/26/05. The number 10 facility policy "Medication Administration via Feeding Tube," with no date, stated, "...7. Stop feedings. 8. Disconnect the feeding tube from administration set or open Y port on the feeding tube. 9. Place stethoscope just below the xiphoid process and instill 10 - 25 cc [cubic centimeters] of air. Listen for a gurgling or whooshing sound to confirm placement. 10. Gently aspirate for stomach contents..." The number 8 facility policy, "Confirming Placement of Feeding Tube via Auscultation and Aspiration," stated, "...Tube placement must be confirmed: a. immediately after insertion. b. Before each feeding and/or flush. c. Before administering medication via tube. d. Every shift or according to facility policy...5. Place stethoscope just below the xiphoid process and instill 10 - 25 cc of air. Listen for a gurgling or whooshing sound to confirm placement. 6. Gently aspirate for stomach contents...8. Return contents to stomach..." a. On 5/30/06 at 4:00 pm, the medication LN was observed giving the resident a medication via the PEG tube. The LN stated, "It's 60 ccs of Effexor	F 322	**SYSTEMIC CHANGES:** Staff was in-serviced on following the policy and procedures for enteral feeding and medication administration on June 13, & 20 2006. **MONITORING:** UM will monitor through direct observation of enteral feeding and medication administration. Staff Development Coordinator (SDC) will monitor through annual skills checks and evaluations. Pharmacy Nurse Consultant will monitor through quarterly medication administration audits. DON will monitor through review of the pharmacy consult report, and annual skill checks. **Date of Compliance July 7, 2006**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 36	F 322		

with 100 ccs of water. The LN stopped the tube feeding formula and disconnected the feeding tube from the administration set. The LN then inserted a Tomey tipped syringe into the port. The PEG was flushed with clean water and the Effexor was instilled via the PEG. Extra water was flushed into the PEG, and the administration line was reattached and the tube feeding formula was restarted.

The LN did not follow the facility policy when a medication was instilled via the PEG tube without first performing the auscultation and aspiration checks to ensure proper placement.

b. On 5/31/06 at 12:30 pm, a LN was observed changing the tube feeding bag and administration line. The LN placed the stethoscope on the abdominal area, near the PEG tube site. Without instilling any air, the LN listened with the stethoscope and stated, "It's growling." The LN then proceeded to aspirate, measure contents, and hook up the new tube feeding apparatus.

The facility policy for confirming feeding tube placement required both auscultation by instilling air into the PEG and listening with a stethoscope as well as aspiration of the gastric contents.

c. The occupational therapy (OT) note, dated 5/11/06, indicated that OT had made changes with positioning and had established a care plan seating schedule to include the resident being up in the wheelchair 2 to 3 hours in the morning and 3 to 4 hours in the afternoon/evening (pm). The note stated, "...Care plan to include proper training of necessary staff - will include pictures of proper seating & positioning. Will trial this system

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 37	F 322		

- may reassess/screen in couple weeks..." Inside the record was a photo with instructions to have the resident up for 2 to 3 hours in the morning and 3 to 4 hours in the pm. Theoretically, the resident could be up 5 to 7 hours a day.

The resident care plan, dated 4/24/06, indicated the resident had been identified as having a feeding tube. The "Approach" section of the care plan stated, "...Feeding solution per curent [sic] MD order...RD [registered dietician] to follow closely and make recommendations as appropriate...May be off tube feed 1 - 2 hrs daily for activities (this approach, unlike the others that were typed, was handwritten) ..."

The monthly tube feed progress note, dated by an RD on 5/24/06, stated, "Tube feeding:...70 cc/hr x 24 hr via PEG/pump. Providing: 1680 cc, 2016 calories...Alb [albumin] 3.3, slightly low...Tube feeding providing adequate protein to meet needs." There was no mention of the resident being off the tube feeding for any length of time during the day, either for activities or OT.

On 5/30/06 at 11:10 am, the resident was observed to not be in his room. A orange sign with black letters was observed to be posted at the head of the bed. The sign stated, "PT [patient] TO BE UP IN W/C [wheelchair] 2 - 3 HOURS IN THE AM AND PM." At 11:20 am, the resident was observed in the TV room. The resident was sitting in the wheelchair and the tube feeding solution was not with the resident.

On 5/30/06 at 4:00 pm, the LN was observed giving medication into the PEG tube. The LN stated, "We get [Resident] up for a couple of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 38	F 322		

hours in the morning and again in the afternoon." The LN explained that when the resident was up in the wheelchair, the tube feeding was discontinued due to dignity reasons.

On 5/31/06 at 8:20 am, a LN was asked, by the surveyor, if there was a doctor's order to have the resident off the continuous tube feeding schedule to accommodate the OT positioning schedule and the activity schedule. The LN could not find an order but stated, "I'll go check."

On 5/31/06 at 9:30 am, the facility's RD approached the surveyor to discusss the tube feeding of the resident. The RD stated, "It's all right for the resident to be off the tube feeding for activities." The RD explained that even with the resident missing 70 to 140 ccs of the feeding solution, he was still getting enough protein. When asked by the surveyor if she (RD) was aware of the OT goal of having the resident up in the wheelchair for several hours a day or that staff felt they had to stop the feeding when up, the RD indicated she was not aware of that change. The RD stated, "It's OK to be off the tube feeding for an hour or 2, he will still meet his protein needs." The RD explained that if the resident was going to be off the tube feeding schedule for longer periods of time his nutrition needs would have to be re-evaluated.

A resident with an RD recommendation and physician's order for a continuous tube feeding via a pump, was taken off the tube feeding schedule to attend activities and meet OT's care plan without the RD and/or physician being notified of the change in care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility did not ensure that hot water temperatures on the "A" unit (100 and 200 halls) remained within a safe temperature range. This affected 3 of 19 sampled residents (#4, 6, and 19) and any other residents residing on the "A" unit who could use the hot water faucet. The findings include: According to the American Society for Hospital Engineering Technical Document 14:2-82, a first degree burn can occur within 2 minutes when the water temperature was 124 degrees Farenheit (F), 45 seconds when the water temperature was 125.6 degrees F and 30 seconds when the water temperature was 127.4 degrees F. At 127.4 degrees F a full thickness second degree burn would occur within 60 seconds. On 5/30/06 at 11:20 am, a surveyor began to check water temperatures on the "A" unit. The following water temperatures were recorded: 1. Room 204 - 124 degrees F. 2. Room 208 - 128 degrees F. 3. Room 210 - 128 degrees F. The surveyor found both the water and the hot water faucets to be too hot to keep a hand in contact with the water or the faucets. The surveyor could only hold her hand under the hot	F 323	**F 323** This facility strives to ensure that the resident environment is kept as free from accident hazards as possible. This includes providing monitoring and equipment to maintain hot water temperatures within a safe range for the population served. **SPECIFIC CONCERN** **"A" Unit Hot Water System:** The circulating pumps for the A-Wing Hot Water system breaker was reset and adjusted to ensure proper temperature control of the hot water during the survey. It should be noted that the water temperatures were checked earlier that same day and were within safe range. The failure of the pumps was an isolated event. **OTHER:** This practice has the potential to affect all residents. Maintenance will continue to perform weekly random water temperature checks on each side of the building. **SYSTEMIC CHANGES:** Maintenance will continue to perform weekly random water temperature checks on each side of the building. Maintenance will continue to perform routine maintenance checks on the boiler and related equipment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 40 water or on the faucets in rooms 208 and 210 for approximately 3 to 4 seconds. The surveyor rechecked the rooms on the 200 hall, with a digital thermometer, at 11:40 am on 5/30/06. The following water temperatures were recorded: 1. Room 201 - 127.2 degrees F. 2. Room 202 - 126.5 degrees F. 3. Room 203 - The resident was using the bathroom and did not want the water temperature taken. 4. Room 204 - 127.5 degrees F. 5. Room 205 - 127.7 degrees F. 6. Room 206 - 127.2 degrees F. 7. Room 207 - 127.7 degrees F. 8. Room 208 - 127.5 degrees F. 9. Room 209 - 126.8 degrees F. 10. Room 210 - 128.6 degrees F. At 12:15 pm, on 5/30/06, the maintenance man was called and checked the water temperatures with the facility's thermometer. The maintenance man recorded the following hot water temperatures: 1. Room 210 - 125 degrees F. The maintenance man stated, "Something is wrong. I can feel the pipe is hot." 2. Room 209 - 124.3 degrees F. 3. Room 202 - 124 degrees F. 4. Room 107 - 122.2 degrees F. The maintenance man stated he wanted to recheck at least one room on the 100 hall since the 200 and 100 halls were on the same water system. The maintenance man left to check the boiler	F 323	Staff was in-serviced on notifying maintenance anytime the water is too hot or cold and on ensuring a safe environment on June 13, 14, 20 and 21st 2006. Staff have been instructed to tactilely check the water temperatures before exposing residents to hot water. **MONITORING:** Maintenance will monitor through weekly water temperature checks. ED will monitor through review of water temperature logs and the monthly PI meetings. **Date of Compliance July 7, 2006**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 41 system. At approximately 12:30 pm on 5/30/06, the maintenance man stated, "I've reset the breaker." The maintenance man explained that the mixing apparatus had shut off and had to be electrically reset.	F 323		
F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, it was determined the facility did not ensure that 1 of 4 sampled residents (#1) who received oxygen therapy was adequately monitored for titration of oxygen. The findings include: According to The seventh edition of "The Lippincott Manual of Nursing Practice," chapter 11 pages 294 - 303 which address the chronic condition of COPD [chronic obstructive pulmonary disease], "...1. Watch for and report excessive somnolence, restlessness, aggressiveness, anxiety, or confusion; central cyanosis; and	F 328	**F 328** This facility strives to provide exceptional care and services for all clinical conditions and complex treatment needs of every resident, within the current clinical practice guidelines and recommendations of recognized experts in the various fields of care. **SPECIFIC RESIDENT** **Resident #1:** Continues to require the use of oxygen. His physician continues to choose not to order blood gases and has indicated it is not necessary for this resident at this time. Oxygen saturations are obtained and documented when the resident displays signs and symptoms of respiratory distress and when the oxygen flow rate is adjusted. **OTHER RESIDENTS:** This practice has the potential to affect all residents that require oxygen. Residents who require oxygen titration will have oxygen saturation checked prior to adjustment of oxygen.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 42 shortness of breath at rest, which frequently is caused by acute respiratory insufficiency and may signal respiratory failure. 2. Review ABGs [arterial blood gases]; record values on a flow sheet so comparisons can be made over time. 3. Monitor oxygen saturation and give supplemental oxygen as ordered to correct hypoxemia in a controlled manner. Monitor and minimize CO2 [carbon dioxide] retention. Patients that experience CO2 retention may need lower oxygen flow rates...Normally, CO2 levels in the blood provide a stimulus for respiration. However, in patients with COPD, chronically elevated CO2 impairs this mechanism and low oxygen levels act as stimulus for respiration. Giving a high concentration of supplemental oxygen to persons who retain CO2 may suppress the hypoxic drive, leading to increased hypoventilation, respiratory decompensation, and the development of a worsening respiratory acidosis..." Resident #1 was admitted on 1/14/06 with diagnoses of COPD, anemia and osteoporosis. The physician recapitulation (Recap) orders for the month of May 2006 contained a physician order dated 1/14/06. "O2 4-5L/MIN [oxygen at 4-5 liters per minute] continuous. May increase O2 to maintain Sats > [saturation levels at or above] 90%." This order was not clear as it did not indicate how high the liter flow could be. Nurse progress notes contained documentation as follows for year 2006: 1/14, (5:30 pm)- "...O2 SATS 85% on 4L/NC [nasal canula]. O2 [increased] to 5L/min and O2	F 328	**SYSTEMIC CHANGES:** Licensed staff was in-serviced on oxygen therapy, appropriate parameters for oxygen orders, obtaining saturation levels and for titration of oxygen flow rates on June 13, 14, 20 and 21st 2006. **MONITORING:** UM will monitor through weekly random audits of oxygen administration records until compliance is achieved. DON will monitor through review of the audits and participation in the monthly PI meeting. **Date of Compliance July 7, 2006**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 43 SATS 90%. Will cont[inue] to monitor." 1/15, (3:00 pm)- "...89% on 5L/NC...Anxious d/t SOB [shortness of breath]..." The note did not include documentation for any change of liter flow or for monitoring if it was changed. 1/16, (2:40 pm)- "...Resident alert & awake states his breathing is 'terrible' O2 SAT 95% pm 6L..." 1/16, (4:00 pm)- "...O2 SAT 93% on O2 @ [at] 5L via n/c [nasal cannula]..." 1/17, (illegible)- "...O2 SAT 95%..." (No liter flow documented). 1/18, (not timed)- "...O2 SAT 90%..." (No liter flow documented). Nurse notes continued to document daily the 5L flow until 1/22, when a nurse note indicated "...91% on 6L/NC...Breathing labored [with] activity c/o [complaints of] tightness in chest..." The documentation did not indicate when the liter flow had been increased nor identify if the saturation levels had been under 90% prior to the liter flow increase. Nurse notes documented daily the resident remained on 6L of O2 until 1/31, (12:30 pm) when documentation indicated the resident was "...92% on 8L...SOB on [illegible]. Walks to door with P.T. [Physical Therapy]..." There was no documentation explaining if the nurse who wrote the note changed the liter flow or if that was the liter flow he was on when he became SOB. Similar documentation continued throughout the remainder of nurse progress notes up to 5/22/06 (not timed) when the following was documented: "O2 88% on 8L/NC,..Resp[eration] 28, LS [lung sounds] [with] exp. [expiration] wheezes/diminished. Resident requested Neb[ulizer] tx [treatment] Q [every] 2 [hours] instead of his [illegible] Q 4 hours. c/o [complaints of] SOB. Productive cough with green/brown	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 44	F 328		

sputum. UM [Unit Manager] [illegible] I will contact MD [Medical Doctor]..." The next note was dated 5/22/06, (6:50 pm) and indicated a physician would be in to change out the resident's suprapubic catheter to a larger size. Nothing was noted regarding the resident's breathing or O2. This was the case for all other nurse progress notes through May 2006.

The following information was documented on the medication administration records (MAR):
For April 2006, staff documented initials on each day and each shift to indicate they had checked the resident's oxygen. However, they did not document liter flow or SAT levels. For May 2006, some of the staff on each shift documented their initials and some documented O2 SAT levels. However, there was no liter flow documented.

The resident was observed on 5/31/06 at 8:30 am, 9:00 am, 11:00 am, 12:15 pm and 1:40 pm lying in bed in his room and receiving O2 at 7 1/2 to 8 L per NC. He did not appear in any respiratory distress during these observations. He never got out of bed and took meals and bed baths in his room. This was confirmed in the following interview with staff.

The Unit Manager LN was interviewed (Two surveyors were present) on 5/31/06 at 1:45 pm. The above information from, "The Lippincott Manual of Nursing Practice" regarding the resident's chronic condition of COPD was discussed with the LN. The LN indicated an understanding but stated they follow what ever the physician has ordered. The LN was asked if any recent arterial blood gas labs had been done. The LN looked through the chart and stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 45 the last blood gas lab tests had been completed while the resident was in the hospital and before his admission. The LN said they would do blood gas labs if the physician ordered them. The LN agreed that they were no longer doing daily nurse notes on the resident and that the MAR forms did not provide liter flow rates daily per shift. The LN indicated the resident "desats quickly" and this is why his liter flow is constantly adjusted. She stated the resident does not leave his bed to eat or bathe anymore due to his breathing problems. He also did not participate in physical therapy for the same reason. A few minutes later, the DON agreed that the resident's liter flow was often adjusted for his shortness of breath. The DON then provided a note from the resident's physician which contained the following order, dated 5/31/06: "O2 nasal prong 2 - 9L as needed to maintain SPO2 [oxygen saturation levels] > 85% - 90%." The facility did not adequately monitor resident #1 for the use of his oxygen which had been increased from 4L/per min. at admission to 8L/per min. at the time of the survey. Oxygen SATs in relation to liter flow were not being documented consistently. It was not consistently documented what symptoms were exhibited by the resident which required the increase in his O2 liter flow levels. The facility staff indicated the resident would "desat quickly" and frequently but there was no indication they had talked to the physician regarding obtaining arterial blood gas levels.	F 328		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135123	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 6/2/2006
NAME OF PROVIDER OR SUPPLIER **LIFE CARE CTR TREASURE VALLEY**	STREET ADDRESS, CITY, STATE, ZIP CODE **502 N KIMBALL PL BOISE, ID**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 274	483.20(b)(2)(ii) RESIDENT ASSESSMENT- WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview and record review it was determined the facility did not ensure that a significant change assessment was initiated for 1 of 19 sample residents (#1) who had MDS assessments reviewed. Findings include: Resident #1 was admitted to the facility on 1/14/06 with diagnoses of chronic obstructive pulmonary disease (COPD), anemia and osteoporosis. The resident's admission MDS, dated 1/18/06, documented he required extensive assistance to transfer and limited assistance for walking in his room or in the corridor. He was also coded as continent of bowel and frequently incontinent of bladder. The resident's quarterly MDS, dated 4/12/06, documented he had not transferred, walked in his room or the corridor for the last 7 days. In addition, this assessment documented the resident as incontinent of bowel and was no longer incontinent of bladder due to insertion of a catheter. The MDS Coordinator LN, was interviewed regarding the resident's MDS documentation, on 5/30/06 at approximately 2:30 pm. The LN agreed a significant change should have been completed for resident #1. The interpretive guidance for F274 requires a significant change assessment to be done if there was significant improvement or decline in 2 or more areas. This includes any area where the resident is newly coded as 3, 4, or 8 (Extensive assistance, Total Dependency, activity did not occur). The resident was no longer transferring or walking in his room or the corridor. The newly coded bowel incontinence and placement of a catheter also each counted as declines which would indicate a significant change was necessary. The facility did not complete a significant change for resident #1 who had declines in ADLs and continence status.
F 431	483.60(d) LABELING OF DRUGS AND BIOLOGICALS Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135123	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 6/2/2006
NAME OF PROVIDER OR SUPPLIER **LIFE CARE CTR TREASURE VALLEY**	STREET ADDRESS, CITY, STATE, ZIP CODE **502 N KIMBALL PL BOISE, ID**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 431	Continued From Page 1 applicable. This REQUIREMENT is not met as evidenced by: Based on observations it was determined 1 of 2 medication refrigerators had expired medications. The findings include: On 5/31/06 at approximately 10:30 am, while checking the "A" unit refrigerator, a surveyor found a box labeled as containing Acetaminophen suppositories. In addition to containing Acetaminophen suppositories that did not expire until 2007, the box contained two (2) 650 milligram suppositories with an expiration date of 12/2005. The expired medications were located in the locked medication room located across from the nurse's station on the "A" Unit. A LN was present while the surveyor was checking the medication refrigerator. When she was shown the suppositories she stated, "I'll take care of those. I'll get rid of them." The LN indicated she wasn't sure how suppositories from 2005 ended up in the box and that both the nursing staff and pharmacy do check the refrigerator for expired medications. The LN stated, "someone must have decided to put them in the box."
F 445	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, it was determined the facility did not ensure that items stored in the clean linen rooms were kept up and off the floor. This involved 2 of 2 linen rooms on the "A" unit for the 100 - 200 halls. The findings include: On 5/31/06 at 10:05 am, the clean linen room, located near room 108, was opened. A pillow was lying on the floor. At 1:55 pm, the clean linen room was rechecked and the pillow was lying on the floor. On 5/31/06 at 10:10 am, the clean linen room, located across from the centrally located nurse station, had a foam foot/heel lift stored on the floor. At 1:55 pm, the clean linen room was rechecked and the foot/heel lift was lying on the floor. Shelving for the proper storage of linens was not utilized resulting in the pillow and a foot/heel lift being improperly stored on the floor.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual State licensure survey of your facility. The surveyors conducting the survey were: Lorna Bouse, BSW, Team Coordinator Betty Vivian, RN Barbara Franek, RN Diane Green, RN Kari Head, RD Nicole Martin, RN Survey Definitions: MDS = Minimum Data Set assessment RAP = Resident Assessment Protocol RAI = Resident Assessment Instrument DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	C 000	*This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.* RECEIVED JUN 26 2006 FACILITY STANDARDS	
C 300	02.107,05,d d. Menus shall provide a sufficient variety of foods in adequate amounts at each meal. Menus shall be different for the same days each week and adjusted for seasonal changes. This Rule is not met as evidenced by: Based on observations, resident and staff interviews and review of facility menus, it was determined the facility did not ensure a variety of main and alternate menu item selections were	C 300	**C 300** This facility does strive to provide menus in sufficient variety of foods in adequate amounts at each meal.	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 6/23/06

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 300	Continued From page 1 served. This had the potential to affect 100% of the resident's who ate at the facility, including 17 of 19 sampled residents (#'s 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18 and 19). Findings include: Resident #8 was admitted on 03/28/05 and readmitted on 10/25/05. The last readmission was due to a left below the knee amputation. The resident's diagnoses were: Left below the knee amputation, diabetes, congestive heart failure, hypertension, restless leg syndrome, increased lipids, and mitral valve stenosis. The quarterly MDS, dated 04/22/06, under section B4, (Cognitive skills for daily decision-making), indicated that the resident can make decisions independently that are reasonable and consistent. This assessment also documented the resident did not have any memory problems. Resident #8 was interviewed on 5/30/06 at approximately 11:10 am. The surveyor asked the resident if they enjoyed the food. Resident stated, "I usually eat in my room, but sometimes I go to the large dining room. If there's one problem here, it's the crappy food. The tator tots are cold in the center and the food looks very unappetizing." When asked about the alternate menu, the resident stated, "That's no better and it's usually left-overs from the last few days of meals." On 5/30/06 at 12:10 pm, during the noon meal observation, the alternate meal board read, "5/29 : Chipped Beef." The CNA's delivering the trays were heard asking what the alternate for this meal was and another CNA stated, "it is chipped beef." The main menu choice was fried chicken,	C 300	**SPECIFIC RESIDENT** **Resident #1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18 and 19:** All residents are invited to a monthly menu meeting where they discuss food preferences and desired menu changes for the upcoming month. Resident preferences are taken into earnest consideration while planning for meals. **OTHER RESIDENTS:** All residents are invited to a monthly menu meeting where they discuss food preferences and desired menu changes for the upcoming month. Resident preferences are taken into earnest consideration while planning for meals. **SYSTEMIC CHANGES:** Alternate meals are now planned separately from previous day meals, and are independent of the left-over menu. **MONITORING:** Resident satisfaction with alternate meals will be monitored through the regularly held menu meeting. Resident preferences will continue to be given earnest consideration during menu and meal preparation. **Date of Compliance July 7, 2006**	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 300	Continued From page 2 mashed potatoes, and mixed vegetables. On 5/31/06 at 11:10 am, the noon meal tray line service was observed. At this time the cook was asked what the alternate meal was and she indicated that it was chipped beef. The surveyor asked what the alternative was for the day before and the cook and dietary manager couldn't remember. Then the cook stated, "I think it was chicken yesterday." The main menu choice for this meal was pork with chilies, Spanish rice and creamed corn. At 12:30 pm, multiple residents eating in the main dining room were interviewed about the current meal being served. The following were some comments by some unidentified residents's who wished to remain anonymous: *One resident who had not eaten more than 5% of her meal was asked if she liked the meal and the resident stated, "no." The resident was then asked by the surveyor if she wanted to try the alternate. The resident stated, "no, that's been the same for the last few days. I didn't want it then, and I don't want it now." The resident was asked if she wanted the kitchen to get her anything else. The resident stated, "no, why bother." *A resident was questioned by the surveyor regarding the lunch meal. She said, "Oh, it is OK I guess." The surveyor asked if she knew that she could request an alternate meal. The resident stated, "Yes and I know what that will be. What ever we ate the day before. If I don't like it I just don't eat it." On 6/1/06 at 12:45 pm, the noon meal was observed. The alternate menu choice served to	C 300		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 300	Continued From page 3 residents was pork with chilies and Spanish rice, the same as the main menu choice from the previous day. On 6/1/06 at 12:50 pm, the dietary manager was interviewed. She was asked to provide a list of alternate menus choices for the last two weeks. She indicated they did not have them documented anywhere to save them, however, she could tell me what they were because their policy was to serve the leftovers from the previous day as the alternate menu choice. At this time the dietary manager was informed of the complaints of repetitive food alternatives by residents. The dietary manager indicated that the menu they were using was relatively new and they were still trying to get all the bugs out and that some recipes yielded too much and they had leftovers they needed to use. However, when the surveyor pointed out that chipped beef had been served as the alternate for two meals in a row, she agreed that did not provide variety to the resident's alternative meal choice. The dietary manager indicated they would not serve the exact menu leftovers from the day before as an alternate the next day. She indicated the facility could incorporate leftovers in a different way to ensure variety of the alternate meal was still maintained.	C 300		
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner.	C 361	**Please Refer to F253**	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 361	Continued From page 4 This Rule is not met as evidenced by: Please refer to F253 as it relates to housekeeping services for a sanitary, orderly and comfortable environment.	C 361		
C 393	02.120,04,b b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Please refer to F246 as it relates to a call light not being accessible.	C 393	**Please Refer to F246**	
C 445	02.120,13,c c. The temperature of hot water at plumbing fixtures used by patients/residents shall be between one hundred five degrees (105F) and one hundred twenty degrees (120F) Fahrenheit. This Rule is not met as evidenced by: Please refer to F323 as it relates to safe water temperatures.	C 445	**Please Refer to F323**	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 671	Continued From page 5	C 671		
C 671	02.150,03,b b. Proper handling of dressings, linens and food, etc., by staff. This Rule is not met as evidenced by: Please refer to F445 as it relates to proper storage of linens.	C 671	**Please Refer to F445**	
C 779	02.200,03,a,i i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Please refer to F 272 as it relates to complete and thorough assessments as part of the care planning process.	C 779	**Please Refer to F272**	
C 782	02.200,03,a,iv iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F280 as it relates to care plan requirements for periodic reviews and revisions.	C 782	**Please Refer to F280**	
C 784	02.200,03,b b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F309 as it relates to Quality of	C 784	**Please Refer to F309**	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135123	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR TREASURE VALLEY	502 N KIMBALL PL BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 784	Continued From page 6 Care including a resident's need for the use of ted hose and specialized boots as care planned.	C 784		
C 789	02.200,03,b,v v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please refer to F314 as it relates to prevention of pressure sores.	C 789	**Please Refer to F314**	
C 821	02.201,01,b b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days. This Rule is not met as evidenced by: Please refer to F 431 as it relates to reviewing medications to remove expired drugs.	C 821	**Please Refer to F431**	